THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	ANSWER TO COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

COME NOW the defendants in the above entitled cause, the State of Washington and Christine Gregoire, Attorney General of Washington, by and through their attorneys, Christine Gregoire, Attorney General, and William L. Williams, Senior Assistant Attorney General, and answer the complaint of the plaintiffs as follows:

1. In answer to paragraphs 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7 and 2.8 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

2. Defendants admit the allegations contained in paragraph 2.9 of the plaintiffs' complaint.

3. Answering paragraph 2.10 of plaintiffs' complaint, defendants admit that the Attorney General is the chief legal officer of the State of Washington. Defendants affirmatively allege that the Office of the Attorney General was established in Article 3, § 21 of the Constitution of the State of Washington and further that the powers of the Attorney General are set forth in statute, primarily RCW 43.10. Defendants admit that the Attorney General is a proper party defendant to this lawsuit, but deny that she serves in any representative capacity with respect to other law enforcement officers in the state.

4. Paragraphs 1.1, 1.2 and 2.11 of the complaint appear to be assertions of legal theory and not factual allegations and therefore require no answer. To the extent an answer is required, defendants admit that 42 USC § 1983 may be a basis for a suit alleging violation of Fourteenth Amendment rights, but deny that the existence or operation of RCW 9A.36.060 violates, or threatens a violation of, any rights of any plaintiff; defendants admit

the second sentence of paragraph 1.1, and paragraphs 1.2 and 2.11.

5. Defendants deny the allegations contained in paragraphs 3.1, 3.2, and 3.3 of the plaintiffs' complaint.

6. In answer to paragraph 3.4 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

Defendants allege by way of affirmative defense that plaintiffs have failed to state a claim upon which relief can be granted.

WHEREFORE, having fully answered the complaint of the plaintiffs and having stated an affirmative defense, defendants request that judgment be entered as follows:

1. Dismissing the plaintiffs' complaint;

2. Awarding defendants costs and attorney's fees; and

3. Awarding defendants any additional or further relief which the court finds appropriate or just.

DATED this 11th day of February, 1994.

CHRISTINE GREGOIRE
Attorney General

/s/
William L. Williams
Assistant Attorney General
Attorney for Defendants

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report I-93-8

Subject: Physician Assisted Suicide
(Resolution 3. A-93—Medical Student Section)

Presented by: John Glasson, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Louis R. Zako, MD, Chair)

Introduction[50]

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has longstanding policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report. "Decisions Near the End of Life."[1] In that report, the Council concluded that physician assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not . . . participate in assisted suicide."[1] Previously, the Council had issued reports

rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia—is contrary to pub-

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50 In accordance with the Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws (I-91), this report may be adopted, not adopted, or referred. It may only be amended, with the concurrence of the Council, to clarify its meaning.

lic policy, medical tradition, and the most fundamental measures of human value and worth."[2] Similarly in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.'"[3]

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins (NY Times, June 6, 1990:A1). The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull.[4] Other public events quickly followed. Physician assisted suicide, together with euthanasia, was placed on the public ballot in Washington State, in November 1991, and in California in November 1992. Both times, voters turned down proposals to legalize physician assisted dying (USA Today, August 9, 1993:13A). In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide (NY Times, October 1, 1993:A8). In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician assisted suicide.

Definitions

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician admin-isters the death-causing drug or other agent.[5]

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.[1]

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.[1]

Ethical Considerations

1. Inappropriate extension of the right to refuse treatment. In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."[1]

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-

determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.[6(p.121)]

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible.[7] The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of lifesustaining treatment, society does not limit the right

to refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.[8]

2. The physician's role. The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain.[9] Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled.[10,11] Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of

physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary to fully relieve the patient's pain.[9] The patient's treatment plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decision maker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients, and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addic-tion or of causing death through respiratory depression.[1]

Relieving the patient's psychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal psychological and spiritual support of family and friends."[12] Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention.[13] Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/or anti-depressant medica-tions. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued.[14,15,16] Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can

go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation and other comfort care for the associated discomfort.

3. "Slippery slope" concerns. Permitting assisted suicide opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands,[17] however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision-maker since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

Recommendations

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

4. Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

REFERENCES

1. Council on Ethical and Judicial Affairs. American Medical Association. Decisions near the end of life. JAMA. 1992; 267:2229-2233.
2. Judicial Council. Terminal illness. In: Proceedings of the House of Delegates: 126th Annual Convention. Chicago, III: American Medical Association; 1977:106-110.
3. Council on Ethical and Judicial Affairs. American Medical Association. Code of Medical Ethics: Reports, vol I. Chicago, III: American Medical Association; 1992:45-46.
4. Quill TE. Death and dignity—a case of individualized decision making. N Engl J Med. 1991; 324:691-694.
5. Orentlicher D. Physician participation in assisted suicide. JAMA. 1989; 262:1844-1845.
6. Weir RF. The morality of physician-assisted suicide. Law Medicine Health Care. 1992; 20:116-126
7. Kass LR. Neither for love nor money: why doctors must not kill. Public Interest. 1989; 94:25-46.
8. Doerflinger R. Assisted suicide: pro-choice or anti-life? Hastings Center Report. 1989; 19(1):S16-S19.
9. Wanzer SH, Federman DD, Adelstein SJ, et al. The physician's responsibility towards hopelessly ill patients: a second look. N Engl J Med. 1989; 320:844-849.
10. Foley KM. The relationship of pain and symptom management to patient requests for physician-assisted suicide. J Pain Symptom Management. 1991; 5:289-297.
11. Foley KM. The treatment of cancer pain. N Engl J Med. 1985; 313:84-95.

12. Brody H. Assisted death—a compassionate response to a medical failure. N Engl J Med. 1992; 327:1384-1388.
13. Conwell Y, Caine ED. Rational suicide and the right to die: reality and myth. N Engl J Med. 1991; 325:1100-1102.
14. Miller RJ. Hospice care as an alternative to euthanasia. Law Medicine Health Care. 1992; 20:127-132.
15. Bulkin W. Lukashok H. Rx for dying the case for hospice. N Engl J Med. 1988; 318:376-378.
16. Mor V. The Hospice Experiment. Baltimore, Md: Johns Hopkins University Press; 1988.
17. van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. Lancet. 1991; 338:669-674.

Council Report

Decisions Near the End of Life [51][52]

Council on Ethical and Judicial Affairs

American Medical Association

OVER the last 50 years, people have become increas-ingly concerned that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity. In one public opinion poll, 68% of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."[1] A number of comparable surveys indicate similar public sentiment.[2]

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51 From the Council on Ethical and Judicial Affairs American Medical Association, Chicago, Ill.

This report is an abridged version of Report B adopted by the House of Delegates of the American Medical Association at the 1991 Annual Meeting.

Reprint requests to the Council on Ethical and Judicial Affairs, American Medical Association, 515 N State St, Chicago, IL 60610 (David Orentlicher, MD, JD).

52 Members of the Council on Ethical and Judicial Affairs include the following: Richard J. McMurray, MD, Flint, Mich, Chair; Oscar W. Clarke, MD, Gallipolis, Ohio, Vice Chair; John A. Barrasso, MD, Casper, Wyo; Dexanne B. Clohan, Arlington, Va; Charles H. Epps, Jr., MD, Washington, DC; John Glasson, MD, Durham, NC; Robert McQuillan, MD, Kansas City, MO; Charles W. Plows, MD, Anaheim, Calif; Michael A. Puzak, MD, Arlington, Va; David Orentlicher, MD, JD, Chicago, Ill, Secretary and staff author; Kristen A. Haikola, Chicago, Ill, Associate Secretary and staff author; and Anita K. Schweickart, Chicago, Ill, Staff Associate and principal staff author.

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Decisions Near the End of Life—Council on Ethical and Judicial Affairs
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Since the turn of the century, there has been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. Now most people die in hospitals or long-term care facilities. Approximately 75% of all deaths in 1987 occurred in hospitals and long-term care institutions,[3] up from 50% in 1949, 61% in 1958, and 70% in 1977.[4] This transition from the privacy of the home to medical institutions has increased public awareness and concern about medical decisions near the end of life. "Since deaths which occur in institutions are more subject to scrutiny and official review, decisions for death made there are more likely to enter public consciousness."[5]

The development of sophisticated life support technologies now enables medicine to intervene and forestall death for most patients. Do-not-resuscitate orders are now commonplace.[6] The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1404 500 persons were receiving artificial nutritional support.[7] This growing capability to forestall death has contributed to the increased attention to medical decisions near the end of life.[5]

The Council has issued opinions on withdrawing and withholding life-prolonging treatment from patients who are terminally ill or permanently unconscious and has also published reports concerning do-not-resuscitate orders,[9,10] euthanasia,[11] and withdrawal of life—prolonging treatment from permanently unconscious patients.[12] This report will re-examine the Council's existing positions and will expand the analysis to include physician-assisted suicide and withdrawing or withholding life-sustaining treatment for patients who are neither terminally ill nor permanently unconscious. The report will focus on competent patients in nonemergency situations. The issue of decisions near

the end of life for incompetent patients is addressed in a separate report by the Council.[13]

DEFINITIONS

The decisions near the end of life examined in this report are those decisions regarding actions or intentional omissions by physicians that will foreseeably result in the deaths of patients. In particular, these decisions concern the withholding or withdrawing of life-sustaining treatment, the provision of a palliative treatment that may have fatal side effects, euthanasia, and assisted suicide.

Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. At one time, the term *passive euthanasia* was commonly used to describe withholding or withdrawing life-sustaining treatment. However, many experts now refrain from using the term passive euthanasia.

The provision of a palliative treatment that may have fatal side effects is also described as *double-effect euthanasia*. The intent of the treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a foreseeable potential effect of the treatment. An example is gradually increasing the morphine dosage for a patient to relieve severe cancer pain, realizing that large enough doses of morphine may depress respiration and cause death.

Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. In this report, the term euthanasia will signify the medical administration of a lethal agent to a patient for the purpose

of relieving the patient's intolerable and incurable suffering.

Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. *Nonvoluntary euthanasia* is the provision of euthanasia to an incompetent person according to a surrogate's decision. *Involuntary euthanasia* is euthanasia performed without a competent person's consent. This report will not examine involuntary euthanasia further, since it clearly would never be ethically acceptable.

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life-ending action (eg, administering a lethal injection). *Assisted suicide* occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

Discussions about life-ending acts by physicians often refer to the patient's "competence" or "decision-making capacity." The two terms are often used interchangeably. However, *competence* can also refer to a legal standard regarding a person's soundness of mind. *Decision-making capacity* signifies the ability to make a particular decision and is not considered a legal standard. "Competence" for the Council's purposes will mean "decision-making capacity."

The evaluation of a person's decision-making capacity is an assessment of the person's capabilities for understanding, communicating, and reasoning. Patients should not be judged as lacking decision-making capacity based on the view that what they decide is unreasonable." People are entitled to make decisions that others think are foolish

as long as their choices are arrived at through a compe-tently reasoned process and are consistent with their personal values.

ETHICAL FRAMEWORK

Determining the ethical responsibilities of physicians when patients wish to die requires a close examination of the physician's role in society. Physicians are healers of disease and injury, preservers of life, and relievers of suffering. Ethical judgments become complicated, however, when these duties conflict. The four instances in which physicians might act to hasten death or refrain from prolonging life involve conflicts between the duty to relieve suffering and the duty to preserve life.

The considerations that must be weighed in each case are: (1) the principle of patient autonomy and the corresponding obligation of physicians to respect patients' choices; (2) whether what is offered by the physician is sound medical treatment; and (3) the potential consequences of a policy that permits physicians to act in a way that will foreseeably result in patients' deaths.

Patient Autonomy

The principle of patient autonomy requires that competent patients have the opportunity to choose among medically indicated treatments and to refuse any unwanted treatment. Absent countervailing obligations, physicians must respect patients' decisions. Treatment decisions often involve personal value judgments and preferences in addition to objective medical considerations. We demonstrate respect for human dignity when we acknowledge "the freedom [of individuals] to make choices in accordance with their own values."[15]

Sound Medical Treatment

The physician's obligation to respect a patient's decision does not require a physician to provide a treatment that is not medically sound. Indeed, physicians are ethically prohibited from offering or providing unsound treatments. Sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.

This criterion of soundness arises from the medical ethical principles of beneficence and nonmaleficence. The principle of *nonmaleficence* prohibits physicians from using their medical knowledge or skills to do harm, on balance, to their patients, while the principle of *beneficence* requires that medical knowledge and skills be used to benefit patients.

Generally, a treatment that is likely to cause the death of a patient violates the principle of nonmaleficence, and a failure to save a patient's life is contrary to beneficence. However, for these decisions near the end of life the patient does not consider his or her death to be an abso-lutely undesirable outcome.

Practical Considerations

Policies governing decisions near the end of life must also be evaluated in terms of their practical consequences. The ethical acceptability of a policy depends on the benefits and costs that result from the policy. In addition to the impact on individual cases (eg, patients will die according to their decision to have life supports withdrawn), there are likely to be serious societal consequences of policies regarding physicians' responsibilities to dying patients.

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is the patient's death.[4] The right of competent patients to forgo life-sustaining treatment has been upheld in the courts (for example, *In re Brooks Estate,* 32 Ill2d 361, 205 NE2d 435 [1965]; *In re Osborne,* 294 A2d 372 [1972]) and is generally accepted by medical ethicists.[4]

Decisions that so profoundly affect a patient's well-being cannot be made independent of a patient's subjective preferences and values.[16] Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death.[7] When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would likely be painful, nauseating, and debilitating. Similarly, when a patient is dying, there may be a choice between returning home to a natural death, or remaining in the hospital, attached to machinery, where the patient's life might be prolonged a few more days or weeks. In both cases, individuals might weigh differently the value of additional life vs the burden of additional treatment.

The withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence. The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When a physician withholds or withdraws a treatment on the request of a

patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withhold-ing is not a treatment, but the forgoing of a treatment.

Some commentators argue that if a physician has a strong moral objection to withdrawing or withholding life-sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patient's wishes.[4] It is true that a physician does not have to provide a treatment, such as an abortion, that is contrary to his or her moral values. However, if a physician objects to withholding or withdrawing the treatment and forces unwanted treatment on a patient, the patient's autonomy will be inappropriately violated even if it will take only a short time for the patient to be trans-ferred to another physician.

Withdrawing or withholding some life-sustaining treatments may seem less acceptable than others. The distinction between "ordinary" vs "extraordinary" treatments has been used to differentiate ethically obligatory vs ethically optional treatments.[17] In other words, ordinary treatments must be provided, while extraordinary treatment may be withheld or withdrawn. Varying criteria have been proposed to distinguish ordinary from extraordinary treatment. Such criteria include customariness, naturalness, complexity, expense, invasive-ness, and balance of likely benefits vs burdens of the particular treatment.[17,18] The ethical significance of all these criteria essentially are subsumed by the last criterion—the balance of likely benefits vs the burdens of the treatment.[17]

When a patient is competent, this balancing must ulti-mately be made by the patient. As stated earlier, the evaluation of whether life-sustaining treatment should be initiated, maintained, or forgone depends on the values and preferences of the patient. Therefore, treatments are not objectively ordinary or extraordinary. For example, artificial nutrition and hydration have frequently been cited as an objectively ordinary treatment which, therefore, must never be forgone. However, artificial nutrition and hydration can be very burdensome to patients. Artificial nutrition and hydration immobilize the patient to a large degree, can be extremely uncomfortable (restraints are sometimes used to prevent patients from removing nasogas-tric tubes), and can entail serious risks (for example, surgical risks from insertion of a gastrostomy tube and the risk of aspiration pneumonia with a nasogastric tube).

Aside from the ordinary vs extraordinary argument, the right to refuse artificial nutrition and hydration has also been contested by some because the provision of food and water has a symbolic significance as an expression of care and compassion.[19] These commentators argue that withdrawing or withholding food and water is a form of abandonment and will cause the patient to die of starvation and/or thirst. However, it is far from evident that providing nutrients through a nasogastric tube to a patient for whom it is unwanted is comparable to the typical human ways of feeding those who are hungry.[18] In addition, discomforting symptoms can be palliated so that a death that occurs after forgoing artificial nutrition and/or hydration is not marked by substantial suffering.[20,21] Such care requires constant attention to the patient's needs. Therefore, when comfort care is maintained, respecting a patient's decision to forgo artificial nutrition and hydration will not constitute an abandonment of the patient, symbolic or otherwise.

There is also no ethical distinction between withdraw-ing and withholding life-sustaining treatment.[4,15,17] Withdrawing life support may be emotionally more difficult than withholding life support because the physician performs an action that hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. However, as most bioethicists now recognize, such a distinction lacks ethical significance.[4,15,17] First, the distinction is often meaningless. For example, if a physician fails to provide a tube feeding at the scheduled time, would it be a with-holding or a withdrawing of treatment? Second, ethical relevance does not lie with the distinction between acts and omissions, but with other factors such as the motivation and professional obligations of the physician. For example, refusing to initiate ventilator support despite the patient's need and request because the physician has been promised a share of the patient's inheritance is clearly ethically more objectionable than stopping a ventilator for a patient who has competently decided to forgo it. Third, prohibiting the withdrawal of life support would inappro-priately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it is initiated, patients and physicians may be more reluctant to begin treatment when there is a possibility that the patient may later want the treatment withdrawn.[4]

While the principle of autonomy requires that physicians respect competent patients' requests to forgo life-sustaining treatments, there are potential negative consequences of such a policy. First, deaths may occur as a result of uninformed decisions or from pain and suffering that could be relieved with measures that will not cause the patient's death. Further, subtle or overt pressures from family, physicians, or society to forgo life-sustaining treatment may render the patient's choice less than free.

These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

The physician must ensure that the patient has the capacity to make medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. In particular, physicians must be aware that the patient's decision-making capacity can be diminished by a misunderstanding of the medical prognosis and options or by a treatable state of depression. It is also essential that all efforts be made to maximize the comfort and dignity of patients who are dependent on life-sustaining treatment and that patients be assured of these efforts. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that could be palliated.

The potential pressures on patients to forgo life- sustaining treatments are an important concern. The Council believes that the medical profession must be vigilant against such tendencies, but that the greater policy risk is of undermining patient autonomy.

PROVIDING PALLIATIVE TREATMENTS THAT MAY HAVE FATAL SIDE EFFECTS

Health care professionals have an ethical duty to provide optimal palliative care to dying patients. At present, many physicians are not informed about the appropriate doses, frequency of doses, and alternate modalities of pain control for patients with severe chronic pain. In particular, inappropriate concerns about addiction too often inhibit physicians from providing adequate analgesia to dying patients. Physicians should inform the patient and the family that concentrated efforts to relieve pain will be a priority in the care of the patient, since fear

of pain is "one of the most pervasive causes of anxiety among patients, families and the public."[2]

The level of analgesia necessary to relieve the patient's pain, however, may also have the effect of shortening the patient's life. The Council stated in its 1988 report on euthanasia that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."[11] The Council maintains this position and further emphasizes that a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

The ethical distinction between providing palliative care that may have fatal side effects and providing euthanasia is subtle because in both cases the action that causes death is performed with the purpose of relieving suffering. The intent of the former is to relieve suffering despite the fatal side effects, while the intent of the latter is to cause death as a means by which relief of suffering is achieved. Most medical treatments entail some undesirable side effects. In general, the patient has a right to decide either to risk the side effects or to forgo the treatment. It does not follow from this reasoning that a patient also has a right to choose euthanasia as a medical treatment for their suffering.

An important concern is that patients who are not fully informed about their prognosis and options may make decisions that unnecessarily shorten their lives. In addition, severe pain might diminish the patient's capacity to decide whether to choose a treatment that risks death. Caution when determining decision-making capacity in this situ-

ation, therefore, must be exercised, and patients should be fully informed.

EUTHANASIA

Euthanasia is the medical administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering. Whether or not a physician may use the skills or knowledge of medicine to cause an "easy" death for a patient who requests such assistance has been debated as early as the time of Hippocrates. Recently, euthanasia has been gaining support from the public and some in the medical profession. In the Netherlands, while physician-performed euthanasia remains illegal, physicians have not been prosecuted since 1984 when they follow certain criteria.[23] These criteria include that (1) euthanasia is explicitly and repeatedly requested by the patient and there is no doubt that the patient wants to die; (2) the mental and physical suffering is severe with no prospect for relief; (3) the patient's decision is well-informed, free, and enduring; (4) all options for alternate care have been exhausted or refused by the patient; and (5) the physician consults another physician.[24] The frequency of euthanasia in the Netherlands has been estimated to range from 2000 to 20000 persons per year.[23] Recently, the first nationwide study of the practice of euthanasia in the Netherlands estimated the incidence of euthanasia to be 1900 persons per year.[25]

In the United States there has been growing public support for legalized euthanasia. The Hemlock Society, an organization dedicated to legalizing voluntary euthanasia and assisted suicide, has doubled its membership in the past 5 years to approximately 33000.[26] Recently, an initiative in Washington State that would have legalized euthanasia for terminally ill patients was put to a vote. Although the ini-

tiative was unsuccessful, 44% of the voters supported the initiative.[27]

Though the principle of patient autonomy requires that competent patients be given the opportunity to choose among offered medical treatments and to forgo any treatment, it does not give patients the right to have a physician perform a treatment to which the physician has objections. Though patients have a right to refuse life-sustaining treatment, they do not have a right to receive euthanasia. There is an autonomy interest in directing one's death, but this interest is more limited in the case of euthanasia than in the case of refusing life support.

The question remains whether it is ethical for a physician to agree to perform euthanasia. To approach this question one must look to the principles of beneficence and nonmaleficence and to the larger policy implications of condoning physician-performed euthanasia.

Can euthanasia ever constitute sound medical treatment? Any treatment designed to cause death is generally considered detrimental to the patient's well-being, and therefore unsound. However, proponents of euthanasia argue that euthanasia is a sound treatment of last resort for the relief of intolerable pain and suffering. From the perspective of competent patients who request euthanasia in the face of such suffering, death may be preferable, on balance, to continued life.

On the other hand, most pain and suffering can be alleviated. The technology of pain management has advanced to the point where most pain is now controllable. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.[22]

There may be cases, however, where a patient's pain and suffering is not reduced to a tolerable level and the patient requests a physician to help him or her die.[2,22] If a patient's pain and suffering are unrelievable and intolerable, using medical expertise to aid an easy death on the request of the patient might seem to be the humane and beneficent treatment for the patient.

However, there are serious risks associated with a policy allowing physician-performed euthanasia. There is a long-standing prohibition against physicians killing their patients, based on a commitment that medicine is a profession dedicated to healing, and that its tools should not be used to cause patients' deaths. Weakening this prohibition against euthanasia, even in the most compelling situations, has troubling implications.[28,29] Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Two noted ethicists have expressed the role of this prohibition:

> The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.[17]

If euthanasia by physicians were to be condoned, the fact that physicians could offer death as a medical treatment might undermine public trust in medicine's dedication to preserving the life and health of patients.[26] Some patients may fear the prospect of involuntary or nonvoluntary euthanasia if their lives are no longer deemed valuable as judged by physicians, their family, or society.[30] Other patients who trust their physicians' judgments may not feel

free to resist the suggestion that euthanasia may be appropriate for them.[30-32]

Another risk is that physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death. Caring for dying patients is taxing on physicians who must face issues of their own mortality in the process, and who often perceive such care as a reminder of their failure to cure these patients.[4,15] In addition, the increasing pressure to reduce health care costs may serve as another motivation to favor euthanasia over longer-term comfort care.

Allowing physicians to perform euthanasia for a limited group of patients who may truly benefit from it will present difficult line-drawing problems for medicine and society. In specific cases it may be hard to distinguish which cases fit the criteria established for euthanasia. For example, if the existence of unbearable pain and suffering was a criterion for euthanasia, the definition of unbearable pain and suffering could be subject to different interpre-tations.

Furthermore, determining whether a patient will benefit from euthanasia requires an intimate understanding of the patient's concerns, values, and pressures that may be prompting the euthanasia request. In the Netherlands, physicians who provide euthanasia generally have a lifelong relationship with the patient and the patient's family, which enables the physician to have access to this vital information.[33] In the United States, however, physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's request for euthanasia.

More broadly, the line-drawing necessary for the establishment of criteria for euthanasia is also problematic.

If competent patients can receive euthanasia, can family members request euthanasia for an incompetent patient? Would it be acceptable for physicians to perform euthanasia on any competent individuals who request it? Furthermore, since it will be physicians and the state who ultimately answer these questions, value judgments about patients' lives will be made by a person or entity other than the patients.

Since it is unclear at this time where these lines should be drawn, the proposition of allowing euthanasia is particu-larly troublesome. A potential exists for a gradual distor-tion of the role of medicine into something that starkly contrasts with the current vision of a profession dedicated to healing and comforting.

Furthermore, in the United States there is currently little data regarding the number of euthanasia requests, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers. Before euthanasia can ever be considered a legitimate medical treatment in this country, the needs behind the demand for physician-provided euthanasia must be examined more thoroughly and addressed more effectively. A thorough examination would require a more open discussion of euthanasia and the needs of patients who are making requests. The existence of patients who find their situations so unbearable that they request help from their physicians to die must be acknowledged, and the concerns of these patients must be a primary focus of medicine. Rather than condoning physician-provided euthanasia, medicine must first respond by striving to identify and address the concerns and needs of dying patients.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide has only recently become the focus of public attention. In June 1990, Dr Jack Kevorkian assisted the death of a person with the use of a "suicide machine," which he invented. This case has been criticized by many for the irresponsible way in which it was carried out by the physician.[26] Kevorkian has since used his suicide machine to assist the suicides of two more persons. Last March, an article was published in the *New England Journal of Medicine* by a physician who described his role in assisting his patient's suicide.[34] The care and compassion evidenced by the physician and the reasoned decision-making process of the patient marked this account as truly compelling. Besides these very public cases of physician-assisted suicide, there is reason to believe that it has been occurring for some time.[2]

There is an ethically relevant distinction between euthanasia and assisted suicide that makes assisted suicide an ethically more attractive option. Physician-assisted suicide affords a patient a more autonomous way of ending his or her life than does euthanasia. Since patients must perform the life-ending act themselves, they would have the added protection of being able to change their minds and stop their suicides up until the last moment.

However, the ethical objections to physician-assisted suicide are similar to those of euthanasia since both are essentially interventions intended to cause death. Physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also has many of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide. Further, determining the criteria for assisting a patient's suicide and determining whether

a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.

While in highly sympathetic cases physician-assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time. The medical profession instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care.

CONCLUSIONS

* The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

* There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

* Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

* Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain con-

trol may decrease dramatically the demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician-assisted suicide at this time.

References

1. Associated Press/Media General. Poll No. 4. Richmond, Va: Media General; February 1985.

2. Wanzer SH, Federman DD, Adelstein SJ, et al. The physician's responsibility toward hopelessly ill patients. *N Engl J Med*. 1989;320:844-849.

3. National Center for Health Statistics. *Vital Statistics of the United States, 1987, H: Mortality, Part A*. Washington, DC: US Public Health Service; 1990.

4. *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*. Washington, DC: President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; 1987.

5. Capron AM. Legal and ethical problems in decisions for death. *Law Med Health Care*. 1986;14: 141-144.

6. Lipton HL. Do-not-resuscitate decisions in a community hospital. *JAMA*. 1986;256:1164-1169.

7. Office of Technology Assessment Task Force. *Life-Sustaining Technologies and the Elderly*. Philadelphia, Pa: Science Information Resource Center; 1988.

8. Council on Ethical and Judicial Affairs. *Current Opinions.* Chicago, Ill: American Medical Association; 1989:13.

9. Council on Ethical and Judicial Affairs. Do-not resuscitate orders: report B. In: Proceedings of the House of Delegates of the AMA; December 1987; Chicago, Ill:170-171.

10. Council on Ethical and Judicial Affairs. Guidelines for the appropriate use of do-not-resuscitate orders: report D. In: Proceedings of the House of Delegates of the AMA; December 1990; Chicago, Ill: 180-185.

11. Council on Ethical and Judicial Affairs. Euthanasia: report C. In: Proceedings of the House of Delegates of the AMA; June 1988; Chicago, Ill:258-260.

12. Council on Ethical and Judicial Affairs and the Council on Scientific Affairs. Persistent vegetative state and the decision to withdraw or withhold life support: joint report. In: Proceedings of the House of Delegates of the AMA; June 1989; Chicago, Ill:314318.

13. Council on Ethical and Judicial Affairs. Decisions to forego life-sustaining treatment for incompetent patients: report D. In: Proceedings of the House of Delegates of the AMA; June 1991; Chicago, Ill:261-269.

14. Buchanan AE, Brock DW. *Deciding for Others. The Ethics of Surrogate Decisionmaking.* New York, NY: Cambridge University Press; 1989.

15. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying: A Report by the Hastings Center.* Briarcliff Manor, NY: Hastings Center; 1987.

16. Brock DW. Death and dying. In: Veatch RM, ed. *Medical Ethics.* Boston, Mass: Jones & Bartlett Publishing Inc; 1989.

17. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 3rd ed. New York, NY: Oxford University Press; 1989.

18. Lynn J, Childress JF. Must patients always be given food and water? *Hastings Cent Rep.* October 1983:17-21.

19. Ramsey P. *The Patient as Person.* New Haven, Conn: Yale University Press; 1970:113-129.

20. Schmitz P, O'Brien M. Observations on nutrition and hydration in dying patients. In: Lynn J, ed. *By No Extraor-*

dinary Means: The Choice to Forego Life-Sustaining Food and Water. Bloomington, Ind: Indiana University Press; 1986.

21. Billings JA. Comfort measures for the terminally ill: is dehydration painful? *J Am Geriatr Soc.* 1985; 33:808-810.

22. Rhymes J. Hospice care in America. *JAMA.* 1990;264:369-372. 23. de Wachter MAM. Active euthanasia in the Netherlands. *JAMA.* 1989; 262:3316-3319.

24. Rigter H. Euthanasia in the Netherlands: distinguishing facts from fiction. *Hastings Cent Rep.* 1989:19(suppl):31-32.

25. Van der Maas P, van Delden J, Pijnenborg L, Looman C. Euthanasia and other medical decisions concerning the end of life. *Lancet.* 1991:338:669-674.

26. Gelman D, Springen K. The doctors suicide van. *Newsweek.* June 18, 1990:46-49.

27. Metz B. Despite defeat of state's suicide initiative, issue still unsettled. *Am Med News.* November 18, 1991:29.

28. Sprung CL. Changing attitudes and practices in forgoing life-sustaining treatment. *JAMA.* 1990; 263:2211-2215.

29. Lifton RJ. *The Nazi Doctors: Medical Killing and the Psychology of Genocide.* New York, NY: Basic Books Inc; 1986.

30. Kass LR. Neither for love nor money: why doctors must not kill. *Public Interest.* 1989;94:25-46.

31. Orentlicher D. Physician participation in assisted suicide. *JAMA.* 1989;262:1844-1845.

32. Kamisar Y. Some non-religions views against proposed mercy-killing legislation. *Minn Law Rev.* 1958;42:969-1042.

33. Battin MP. Remarks at University of Florida Colleges of Medicine and Nursing conference: Controversies in the

Care of the Dying Patient. Orlando, Fla. February 14, 1991.

34. Quill TE. Death and dignity: a case of individualized decision making. *N Engl J Med.* 1991;324: 691-694.

MODEL PENAL CODE

§ 210.5 Causing or Aiding Suicide

. . .

(2) **Aiding or Soliciting Suicide as an Independent Offense.** A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor.

STATE STATUTES

ALASKA

Sec. 1141.120. Manslaughter. (a) A person commits the crime of manslaughter if the person

. . .

(2) intentionally aids another person to commit suicide.

ARIZONA

§ 13-1103. Manslaughter; classification

A. A person commits manslaughter by:

. . .

3. Intentionally aiding another to commit suicide; or

ARKANSAS

5-10-104. Manslaughter.

. . .

(2) He purposely causes or aids another person to commit suicide;

CALIFORNIA

§ 401. Suicide; aiding, advising, or encouraging

Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.

COLORADO

18-3-104. Manslaughter. (1) A person commits the crime of manslaughter if:

. . .

(b) Such person intentionally causes or aids another person to commit suicide; or

CONNECTICUT

§ 53A-56. Manslaughter in the second degree: Class C felony

(a) A person is guilty of manslaughter in the second degree when: . . . (2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide.

Commission Comment—1971

Manslaughter in the second degree. This section covers two types of homicide: recklessly causing the death of another; and intentionally causing or aiding another person to commit suicide.

. . .

The second part, causing or aiding a suicide, is aimed at such situations as aiding, out of the feelings of sympathy, the suicide of one inflicted with a painful and incurable disease. While such conduct is blameworthy, the possible mitigating circumstances justify its treatment as manslaughter, rather than murder.

DELAWARE

§ 645. Promoting suicide; class F felony [Amendment effective with respect to crimes committed June 30, 1990, or thereafter].

A person is guilty of promoting suicide when he intentionally causes or aids another person to attempt suicide, or when he intentionally aids another person to commit suicide.

FLORIDA

782.08. Assisting self-murder

Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

ILLINOIS

12-31. Inducement to commit suicide

§ 12-31. Inducement to Commit Suicide. (a) A person commits the offense of inducement to commit suicide when he coerces another to commit suicide and the other person commits suicide as a direct result of the coercion, and he exercises substantial control over the other person through (1) control of the other person's physical location or circumstances; (2) use of psychological pressure; or (3) use of actual or ostensible religious, political, social, philosophical or other principles.

INDIANA

35-42-1-2.5 Assisting suicide.—(a) This section does not apply to the following:

(1) A licensed health care provider who administers, pre-

scribes, or dispenses medications or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.

(2) The withholding or withdrawing of medical treatment or life-prolonging procedures by a licensed health care provider, including pursuant to IC 16-8-11 (living wills and life-prolonging procedures), IC 16-8-12 (health care consent), or IC 30-5 (power of attorney).

(b) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following commits assisting suicide, a Class C felony:

(1) Provides the physical means by which the other person attempts or commits suicide.

(2) Participates in a physical act by which the other person attempts or commits suicide.

KANSAS

21-3406. Assisting suicide. Assisting suicide is intentionally advising, encouraging or assisting another in the taking of the other's life which results in a suicide or attempted suicide.

Assisting suicide is a severity level 9, person felony.

MAINE

§ **204. Aiding or soliciting suicide**

1. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide.

2. Aiding or soliciting suicide is a Class D crime.

Comment to former section 206—1975

There is no counterpart to this section in the present law. It is included in the code in order to deter conduct aimed at causing another to take his life. The participation of the victim in bringing

about his own death does not make the forbidden conduct free from fault. The requirement that there be a successful or unsuccessful suicide attempt adds a safeguard designed to corroborate the defendant's intention. [Footnote omitted.]

MICHIGAN

AN ACT to • **[**prohibit certain acts pertaining to the assistance of suicide**]**; to provide for the development of legislative recommendations concerning certain issues related to death and dying **[**, including assistance of suicide**]**; • **[**to create the Michigan commission on death and dying**]**; **[**to prescribe its membership, powers, and duties;**]** to prescribe penalties; and to repeal certain parts of this act on a specific date.

§**28.547(121) Commission on death and dying; creation.]** Sec. 1. (1) The legislature finds that the voluntary self-termination of human life, with or without assistance, raises serious ethical and public health questions in the state. To study this problem and to develop recommendations for legislation, the Michigan commission on death and dying is created.

Effective date.] **[**(2) This section shall take effect February 25, 1993.**]** (MCL §752.1021.)

§**28.547(122) Definitions.]** Sec. 2. (1) As used in this act:

(a) "Commission" means the Michigan commission on death and dying created in section 3.

(b) "Legislative council" means the legislative council established under section 15 of article IV of the state constitution of 1963.

(c) "Licensed health care professional" means any of the following;

(i) A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code **[**, being sections 333.17001 to 333.17088 and 333.17501 to 333.17556 of the Michigan Compiled Laws**]**.

(ii) A registered nurse or licensed practical nurse licensed or authorized to practice under part 172 of the public health code **[**, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws**]**.

(iii) A pharmacist licensed under part 177 of the public health code**[**, being sections 333.17701 to 333.17770 of the Michigan Compiled Laws**]**.

(d) "Patient" means a person who engages in an act of voluntary self-termination.

(e) "Public health code" means Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(f) "The voluntary self-termination of life", "voluntary self-termination", and "self-termination" mean conduct by which a person expresses the specific intent to end, and attempts to cause the end of, his or her life, but do not include the administration of medication or medical treatment intended by a person to relieve his or her pain or discomfort, unless that administration is also independently and specifically intended by the person to cause the end of his or her life.

Effective date.] [(2) This section shall take effect February 25, 1993.**]** (MCL §752.1022.)

§**28.547(123) Nomination and appointment of members.]** Sec. 3.(1) The Michigan commission on death and dying is created within the legislative council. In ac-

cordance with its own rules and procedures, each of the following may nominate 2 persons for appointment to the commission:

(a) American association of retired persons.

(b) American civil liberties union of Michigan.

(c) Citizens for better care.

(d) Health care association of Michigan.

(e) Hemlock of Michigan.

(f) Michigan association for retarded citizens.

(g) Michigan association of osteopathic physicians and surgeons.

(h) Michigan association of suicidology.

(i) Michigan council on independent living.

(j) Michigan head injury survivor's council.

(k) Michigan hospice organization.

(l) Michigan hospital association.

(m) Michigan nonprofit homes association.

(n) Michigan nurses association.

(o) Michigan psychiatric society.

(p) Michigan psychological association.

(q) Michigan senior advocates council.

(r) Michigan state medical society.

(s) National association of social workers, Michigan division.

(t) Right to life of Michigan, inc.

(u) State bar of Michigan.

(v) Prosecuting attorneys association of Michigan.

Legislative council; selection of commission member and alternate.] (2) Within 30 days after receiving notice of the nominations of an organization listed in subsection (1), the chairperson and alternate chairperson of the legislative council shall select from the nominees of that organization a member and a person to serve as that member's alternate on the commission.

Majority of members to constitute quorum.] (3) A majority of commission members appointed constitute a quorum.

Initial meeting; election of officers; establishment of rules of proceeding; rights of alternate members.] (4) The commission shall convene its first meeting within 90 days after the effective date of this act, at which the members shall elect from members of the commission a chairperson, vice-chairperson, and secretary. The commission shall establish rules governing commission proceedings. These rules shall provide alternate members with full rights of participation, other than voting, in all commission proceedings.

Subsequent meetings; calling of meetings by chair-person or commission majority; notice.] (5) Following its first meeting, the commission shall meet as often as necessary to fulfill its duties under this act. Either the chairperson or a majority of the appointed members may call a meeting upon 7 days' written notice to the commission members.

Deliberations; involvement of members of the public and certain groups.] (6) In its deliberations, the commission shall provide for substantial involvement from the academic, health care, legal, and religious commun-ities, as well as from members of the general public.

Death or absence of member; duties of alternate.] (7) Upon the death or resignation of a commission member, the person serving as his or her alternate shall succeed that member. If a member of the commission is absent from a commission meeting, the person serving as his or her alternate shall act as a member of the commis-sion at that meeting.

Effective date.] [(8) This section shall take effect February 25, 1993.**]** (MCL §752.1023.)

§28.547(124) Recommendations to legislature; factors to consider.] Sec. 4. **[**(1)**]** Within 15 months after the effective date of this act, the commission shall develop and submit to the legislature recommendations as to legislation concerning the voluntary self-termination of life. In developing these recommendations, the commission shall consider each of the following:

(a) Current data concerning voluntary self-termination, including each of the following:

(i) The current self-termination rate in the state, compared with historical levels.

(ii) The causes of voluntary self-termination, and in particular each of the following:

(A) The role of alcohol and other drugs.

(B) The role of age, disease, and disability.

(iii) Past and current Michigan law concerning volun-tary self-termination, including the status of persons who assist a patient's self-termination, and in particular the effect of any relevant law enacted during the 86th Legislature.

(iv) The laws of other states concerning voluntary self-termination, and in particular the effect of those laws on the rate of self-termination.

(b) The proper aims of legislation affecting voluntary self-termination, including each of the following:

(i) The existence of a societal consensus in the state on the morality of the voluntary self-termination of life, including the morality of other persons assisting a patient's self-termination.

(ii) The significance of each of the following:

(A) The attitudes of a patient's family regarding his or her voluntary self-termination.

(B) The cause of a patient's act of self-termination, including apprehension or existence of physical pain, disease, or disability.

(iii) Whether to differentiate among the following causes of voluntary self-termination:

(A) Physical conditions, as distinguished from psychological conditions.

(B) Physical conditions that will inevitably cause death, as distinguished from physical conditions with which a patient may survive indefinitely.

(C) Withdrawing or withholding medical treatment, as distinguished from administering medication, if both are in furtherance of a process of voluntary self-termination.

(iv) With respect to how the law should treat a person who assists a patient's voluntary self-termination, whether to differentiate based on the following:

(A) The nature of the assistance, including inaction; noncausal facilitation; information transmission; encourage-ment; providing the physical means of self-termination; active participation without immediate risk to the person assisting; and active participation that incurs immediate risk to the person assisting, such a suicide pacts.

(B) The motive of the person assisting, including compassion, fear for his or her own safety, and fear for the safety of the patient.

(C) The patient's awareness of his or her true condition, including the possibility of mistake or deception.

(v) The relevance of each of the following:

(A) The legal status of suicide.

(B) The legal status of living wills.

(C) The right to execute a durable power of attorney for health care, as provided in section 496 of the revised probate code, Act No. 642 of the Public Acts of 1978, being section 700.496 of the Michigan Compiled Laws.

(D) The common-law right of a competent adult to refuse medical care or treatment.

(E) Constitutional rights of free speech, free exercise of religion, and privacy, and constitutional prohibitions on the establishment of religion.

(c) The most efficient method of preventing voluntary self-terminations, to the extent prevention is a proper aim of legislation. In particular, the commission shall consider each of the following:

(i) The costs of various methods of preventing voluntary self-terminations, including the use of any of the following:

(A) Public health measures, such as crisis therapy and suicide counseling services.

(B) Tort law.

(C) Criminal law, including the desirability of crimi-nalizing suicide or attempted suicide.

(D) Civil sanctions, including the denial of inheritance and requirements of community service and mandatory counseling.

(ii) The likely effect of any of the methods listed in subparagraph (i) on the self-termination rate, and in particular the probability that a particular method might cause the self-termination rate to increase.

(iii) The impact of any of the methods listed in subparagraph (i) on the practice of medicine and the avail-ability of health care in the state.

(iv) Whether current state law is adequate to address the question of voluntary self-termination in the state.

(d) Appropriate guidelines and safeguards regarding voluntary self-terminations the law should allow, including the advisability of allowing, in limited cases, the admin-istering of medication in furtherance of a process of voluntary self-termination.

(e) Any other factors the commission considers necessary in developing recommendations for legislation concerning the voluntary self-termination of life.

Effective date.] **[**(2) This section shall take effect February 25, 1993.**]** (MCL §752.1024.)

§**28.547(125) Open meetings act; applicability.]** Sec. 5. **[**(1)**]** The business of the commission shall be conducted in compliance with the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

§**28.547(126) Freedom of information act; applica-bility; writings prepared or possessed by commission.]** Sec. 6. **[**(1)**]** A writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function shall be made available to the public in compliance with the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

§**28.547(127) Assistance to suicide; felony; penalty.]** Sec. 7. (1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both:

(a) Provides the physical means by which the other person attempts or commits suicide.

(b) Participates in a physical act by which the other person attempts or commits suicide.

Exception; withholding or withdrawing medical treatment.] (2) Subsection (1) shall • **[**not apply to withholding or withdrawing medical treatment**]**.

Exception; medications and procedures not intended to cause death.] (3) • **[**Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort

and not to cause death, even if the medication or procedure may hasten or increase the risk of death.**]**

Effective date.] [(4) This section shall take effect February 25, 1993.**]**

Prospective repeal.] [(5)**]** • This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4. (MCL §752.1027.)

MINNESOTA

609.215. Suicide

Subdivision 1. Aiding suicide. Whoever intention-ally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000, or both.

Subd. 2. Aiding attempted suicide. Whoever inten-tionally advises, encourages, or assists another who attempts but fails to take the other's own life may be sentenced to imprisonment for not more than seven years or to payment of a fine of not more than $14,000, or both.

Subd. 3. Acts or omissions not considered aiding suicide or aiding attempted suicide. (a) A health care provider, as defined in section 145B.02, subdivision 6, who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.

(b) A health care provider, as defined in section 145B.02, subdivision 6, who withholds or withdraws a life-sustaining procedure in compliance with chapter 145B or

in accordance with reasonable medical practice does not violate this section.

Subd. 4. Injunctive relief. A cause of action for injunctive relief may be maintained against any person who is reasonably believed to be about to violate or who is in the course of violating this section by any person who is:

(1) the spouse, parent, child, or sibling of the person who would commit suicide;

(2) an heir or a beneficiary under a life insurance policy of the person who would commit suicide;

(3) a health care provider of the person who would commit suicide;

(4) a person authorized to prosecute or enforce the laws of this state; or

(5) a legally appointed guardian or conservator of the person who would have committed suicide.

Subd. 5. Civil damages. A person given standing by subdivision 4, clause (1), (2), or (5), or the person would have committed suicide, in the case of an attempt, may maintain a cause of action against any person who violates or who attempts to violate subdivision 1 or 2 for compensatory damages and punitive damages as provided in section 549.20. A person described in subdivision 4, clause (4), may maintain a cause of action against a person who violates or attempts to violate subdivision 1 or 2 for a civil penalty of up to $50,000 on behalf of the state. An action under this subdivision may be brought whether or not the plaintiff had prior knowledge of the violation or attempt.

Subd. 6. Attorney fees. Reasonable attorney fees shall be awarded to the prevailing plaintiff in a civil action brought under subdivision 4 or 5.

MISSISSIPPI

§ 97-3-49. Suicide—aiding.

A person who wilfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of felony and, on conviction, shall be punished by imprisonment in the penitentiary not exceeding ten years, or by fine not exceeding one thousand dollars, and imprisonment in the county jail not exceeding one year.

MONTANA

45-5-105. Aiding or soliciting suicide. (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide.

(2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

NEBRASKA

28-307. Assisting suicide, defined; penalty. (1) A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide.

(2) Assisting suicide is a Class IV felony.

NEW HAMPSHIRE

630:4 Causing or Aiding Suicide.

I. A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide.

II. Causing or aiding suicide is a class B felony if the actor's conduct causes such suicide or an attempted suicide. Otherwise it is a misdemeanor.

NEW JERSEY

2C:11-6. Aiding suicide

A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.

NEW MEXICO

30-2-4. Assisting suicide.

Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth degree felony.

NEW YORK

§ 120.30 Promoting a suicide attempt

A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.

Promoting a suicide attempt is a class E felony.

§ 120.35 Promoting a suicide attempt; when punishable as attempt to commit murder

A person who engages in conduct constituting both the offense of promoting a suicide attempt and the offense of attempt to commit murder may not be convicted of attempt to commit murder unless he causes or aids the suicide attempt by the use of duress or deception.

§ 813. Aiding suicide

Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide.

§ 814. Furnishing weapon or drug

Every person who willfully furnishes another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life, is guilty of aiding suicide, if such person thereafter employs such instrument or drug in taking his own life.

§ 815. Aid in attempt to commit suicide

Every person who willfully aids another in attempting to take his own life, in any manner which by the preceding sections [footnote omitted] would have amounted to aiding suicide if the person assisted had actually taken his own life, is guilty of aiding an attempt at suicide.

§ 816. Incapacity of person committing or attempting suicide no defense

It is no defense to a prosecution for aiding suicide or aiding an attempt at suicide, that the person who committed or attempted to commit the suicide was not a person deemed capable of committing crime.

§ 817. Punishment for aiding suicide

Every person guilty of aiding suicide is punishable by imprisonment in the penitentiary for not less than seven (7) years.

§ 818. Punishment for aiding an attempt at suicide

Every person guilty of aiding an attempt at suicide is punishable by imprisonment in the penitentiary not exceed-ing two (2) years, or by a fine not exceeding One Thousand Dollars ($1,000.00), or both.

OREGON

163.125 Manslaughter in the second degree

(1) Criminal homicide constitutes manslaughter in the second degree when:

. . .

(b) A person intentionally causes or aids another person to commit suicide.

PENNSYLVANIA

§ 2505. Causing or aiding suicide

. . .

(b) Aiding or soliciting suicide as an independent offense.—A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor of the second degree.

SOUTH DAKOTA

22-16-37. Aiding and abetting suicide as felony. Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a Class 6 felony.

TEXAS

§ 22.08. Aiding Suicide

(a) A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.

(b) An offense under this section is a Class C misdemeanor unless the actor's conduct causes suicide or at-

tempted suicide that results in serious bodily injury, in which event the offense is a felony of the third degree.

WISCONSIN

940.12 Assisting suicide

Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony.